# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: -**<br>Bill Sweeney, Chief Executive Officer, Rugby Football Union<br>Rugby House Twickenham Stadium<br>200 Whitton Road<br>Twickenham<br>Middlesex<br>TW2 7BA |
| **1** | **CORONER**<br>I am Peter Nieto, Area Coroner for the coroner area of Derby and Derbyshire |
| **2** | **CORONER'S LEGAL POWERS**<br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| **3** | **INVESTIGATION and INQUEST**<br>On 10 May 2022 I commenced an investigation into the death of Richard James HILL, referred to as Richard for the purposes of the inquest, aged 24. The investigation concluded at the end of the inquest on 13 March 2023. The conclusion of the inquest was that Richard's death was alcohol related. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br>Richard died on 30 April 2022 at a sports and recreation club where his rugby club was holding its annual awards ceremony. Richard had been drinking alcohol all day and at the event and by 21:23 when he collected his trophy he was clearly showing the effects of alcohol inebriation and this was apparent to people at the event, including club members. About thirty minutes later he was unable to walk and had reduced responsiveness and he had to be carried to an outside bench. When it was realised that he was possibly critically unwell an ambulance was called, although medically trained attendees at the club event had started to provide resuscitative interventions, including use of a defibrillator which identified there was no shockable rhythm. Paramedics attended but intensive resuscitation was sadly unable to revive Richard and he was pronounced dead at the scene.<br><br>Richard was known to drink heavily when out with friends and at social events. The court heard evidence from Richard's brother that Richard's alcohol consumption appeared to increase following the death of a close friend in January 2022.<br><br>After Richard's death, as part of post-mortem examination, blood and urine samples were sent for toxicological testing. Toxicology identified a very high level of alcohol in Richard's system, at a level capable of causing death due to alcohol toxicity. Cocaine was also identified in Richard's system but was not considered to be contributory to his death. |
| **5** | **CORONER'S CONCERNS**<br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows: -<br><br>The inquest heard evidence that some people, probably including Richard, were drinking alcohol from trophy cups at the rugby club event and that these were being topped up by various people in the course of the evening, such that the trophy cups contained mixed |

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| | drinks. Post-mortem toxicological analysis of Richard's blood and urine demonstrated a toxic level of alcohol in his system, and he had been drinking alcohol all day, including prior to the event.<br><br>The inquest heard evidence that excess alcohol consumption is likely a problem across all male sports. The rugby club had received educative/campaign material from the Rugby Football Union (RFU) on issues including mental health but not specifically concerning alcohol misuse and alcohol awareness. The club is a local grassroots club, effectively run by volunteers, and it seems to me that the RFU might consider providing guidance and educative material around alcohol use that would potentially be welcome and utilised by affiliate grassroots rugby clubs and could have a positive impact on harmful drinking. |
| **6** | **ACTION SHOULD BE TAKEN**<br>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action. |
| **7** | **YOUR RESPONSE**<br>You are under a duty to respond to this report within 56 days of the date of this report, namely by May 19, 2023. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| **8** | **COPIES and PUBLICATION**<br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted] (parents of Richard)<br>Ashbourne Rugby Union Football Club<br>[redacted] (licensee of the Ashbourne Recreation Ground)<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.<br><br>You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner. |
| **9** | **Dated: 24 March 2023**<br><br>  <br><br>**Peter Nieto**<br>**Area Coroner**<br>**Derby and Derbyshire** |